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DRUG DEMAND REDUCTION PROGRAMME IN INDIA – A QUALITATIVE RESEARCH ANALYSIS

Dr. Sandra Joseph

ABSTRACT

India is a welfare-based nation; therefore, it has an embedded responsibility to protect the marginalized communities. However, drug dependency has always been a hidden phenomenon. Focusing on Indian scenario, this research critically analysed the implementation of the demand reduction programme, i.e. the National scheme of Assistance for Prevention of Alcoholism and Substance abuse which emerged from Section 71 of **Narcotic Drugs and Psychotropic Substances (NDPS) Act.** This research has consolidated an in-depth analysis of the rationale of treatment and rehabilitation components of the scheme, its implementation mechanisms from the Centre to grassroots, its intervention processes at community level and the efficiency of monitoring systems.

The study was carried through participatory approach by including drug dependents, policy makers, lobbyists, Government bodies and de-addiction centres. The study brought out a national perspective by covering Chennai, Mumbai, New Delhi and Mizoram representing Southern, Western, Northern and North East regions of the country respectively. This approach was deployed to obtain a holistic understanding of the country.

Keeping intact the human rights aspect of drug dependents, careful analysis was made by including reflections and critics of all political and social actors in this field. The treatment and rehabilitation services were analyzed categorically and thematically by posing specific standards such as **Availability, Accessibility, Quality and Protection of Human Rights.**

It is hoped that the findings of this study will throw more light into the hidden realities of the drug demand reduction programme in India.

KEYWORDS :

INTRODUCTION

The habitual use of stimulants, sedative and euphoric drugs were prevalent in India long before any other country of the modern world. Earlier, society was self-regulating and did not need precise rules for effective drug control. Drug consumption was carried out openly, legitimized by cultural norms and restricted by traditional demand. With International intervention however, indigenous controls have been displaced by a single model, developed primarily for the West. In the Indian context, the imposition of this model has resulted in the replacement of culturally sanctioned use by secular use and of traditional suppliers by criminal networks. Furthermore, adherence to the United Nations Drug Control Conventions ensures that most nation states adopt a similar prohibition-oriented approach when formulating their national drug control legislation.

With India's position between the Golden triangle and the Golden crescent, it was becoming a transit country for routing drugs to different countries through India. New drugs were also being manufactured synthetically in other countries which were falling off on the Indian soil during transit. The Government thereby brought in the Narcotic Drugs and Psychotropic Substances (NDPS) Act in 1985 with more stringency and concrete prohibition over usage of drugs. The NDPS Act 1985 was the only drug law for dealing with the drug problem in India. It came into force due to the pressure of International Conventions which India was a signatory. Cannabis and opium lost its traditional and indigenous value and became drugs of abuse. The Act did not in any way bring down the rate of drug trafficking but was only causing the drug mafias to improve and update their technology for safe and highly networked trafficking. It was only the small-scale drug peddlers and drug users who were falling prey to the extremely rigorousprovisions of the NDPS Act. According to a UN Report (1999), one million heroin dependents were registered in India, and unofficially there were as many as five million .According to a report titled, "The Extent, Pattern and Trends of Drug Abuse in India: National Survey" by the Ministry of Social Justice and Empowerment and the United Nations Office on Drugs and Crime (UNODC) published in 2004, states that apart from alcohol (62.46 million users), Cannabis (8.75 million users), opiates such as Heroin, opium, buprenorphine and propoxyphene (2.04 million users) and sedatives (0.29 million users) were the drugs most abused.

For the welfare of drug using population, the National Demand Reduction Programme which has its root from Section 71 of the Narcotic Drugs and Psychotropic Substances Act, 1985 was formulated. Section 71 has stated that the Government can establish as many de-addiction centres as possible for the treatment and rehabilitation of drug dependents. Accordingly, from Section 71, the National Scheme of Assistance for Prevention of Alcoholism and Substance Abuse was emerged. As the NDPS Act deals with drug use both from the enforcement and treatment angles, the responsibility of treating drug dependents in the country did not wholly fall in the hands of Ministry of Health. Thereby Ministry of Social Justice and Empowerment approached it as a correctional issue and envisaged a wide range of services for treating addiction. However, the Ministry of Social Justice did not become a direct provider for services, it limited its responsibility by training and providing financial assistance for the NGOs in the field of de-addiction.

Legalization of specific drugs could pave a way for decrease in users involved in drug crimes as they are usually the soft targets of drug mafias. The funds which Government spends for enforcement activities for dealing with drug offences may also decrease. Therefore, the funds could be effectively utilized for treatment, rehabilitation, preventive education and awareness generation. India should soon be adapting the decriminalization approach simultaneously strengthening harm reduction mechanisms and promote preventive education.

METHODOLOGICAL APPROACHES

The aim of this research was to draw up a situational analysis of the current drug policies and rehabilitation practices existing in India, its rationale, formulation, implementation and its relevance to the current reality of new drug use/abuse problem. It further aimed at strengthening and consolidating understandings of such policies and practices concerning the co-operation mechanisms between the Non-Governmental Organizations and the Governments. This study was primarily formulated keeping in line the initiative of the United Nations

of the World Forum on "Beyond 2008" on Drugs use/Abuse and its policies.

Objectives

1. Study policy implementation mechanisms ranging from the central to the community levels with reference to the National Demand Reduction Programme.
2. Analyse strengths and gaps in the demand reduction programme- its rationale, planning, implementation mechanisms, intervention processes, monitoring systems and outcomes.
3. Suggest a knowledge framework so as to enhance the quality of policy formulation and its overall implementation using the inclusive/participatory approach.

Study Design: The study design used for the research was qualitative study design. The study design involved observing and describing the behavior of social and political actors in the field of drug use. It researches and analyzes complexity, sensitive areas, and areas in need of exploration, to discover associations and relations with regard to drug issue. Interviews, focus group discussions, content analysis were the qualitative techniques used in the research.

Sample Design: The study having been qualitative in nature, in-depth interviews with key informants, focus group discussion were used. Nonprobability sampling design was the broader design used for the study. Multistage sampling design was used to identify the geographical regions and for further selection of units of data collection in each region. Multi-stage sampling is a kind of complex sample design in which two or more levels of units are imbedded one in the other. Heterogeneity sampling design complemented with purposive sampling was used to identify the units of data collection. Heterogeneity sampling design is a design which is used to include all opinions or views, and not concerned about representing these views proportionately. Another term for this is sampling for diversity. This design helped in identifying differentstakeholders in the field of drug abuse from outreach workers, recovering drug dependents, teenagers, practitioners, professionals, policy makers, government officials, and experts in the field. However, heterogeneity sampling combined with purposive sampling design enabled the researcher to identify the units of information with maintaining both diversity and as well as sustaining an underlying purpose of seeking specific predefined groups. In effect, sampling was not people, but opinions, perceptions, and ideas in order to obtain the crux of the working of the scheme at the local level.

Secondary sources included Policies Acts, schemes, brochures, manuals, journals, books, reports etc from various agencies namely Narcotics control Bureau, UNODC, Directorate of Social Defense, Ministry of Health and Family Welfare, Ministry of Social Justice and Empowerment, academic institutions, RRTCs, NGOs, Govt. De-addiction centres and Private de-addiction centres etc. Content analysis was done to study all forms of documents the policies, laws and legislations which are available in connection to demand reduction.

MAJOR FINDINGS

The NDPS Act was enacted by Parliament in 1985 in keeping with International Drug Conventions, namely the Single Convention on Narcotic Drugs, 1961; the Protocol amending the Single Convention on Narcotic Drugs, 1972 and the Convention on Psychotropic Substances, 1971. The NDPS Bill, 1985 was passed hastily over four days, without much legislative debate. It received the President's assent on 16 September 1985 and came into force on 14 November 1985. The NDPS Act, 1985 replaced the Opium Act, 1857, the Opium Act, 1878 and the Dangerous Drugs Act, 1930.

According to the Statement of Objects and Reasons of the NDPS Act, 1985, India was becoming a transit for drug trafficking and the then legislation was ineffective in countering the problem. The following deficiencies were noted in the law prevailing at the time – (i) absence of stringent penalties against drug trafficking, ii) weak enforcement powers, iii) development of a vast bodyof International law, which India was a signatory to, and, iv) lack of regulations over psychotropic substances.

Like other International treaties, the drug Conventions to which India was a signatory, were not self-executing. Their provisions were supposed to be incorporated into domestic law by legislative acts, in accordance with constitutional principles and the basic concepts of the legal system of that State. The NDPS Act, 1985 was introduced as a comprehensive legislation to tighten control over abuse on narcotic drugs and psychotropic substances, enhance penalties, especially for trafficking in drugs, strengthen regulations over psychotropic substances and provide for the implementation of International Conventions. Although the NDPS Act was prohibitionist in its approach and has criminalized the use of drugs, it has still inculcated a provision in the Act for treatment and rehabilitation of drug dependents. Section 71 of the NDPS Act has stated that the government can establish as many de-addiction centres as possible for the treatment and rehabilitation of drug dependents. Accordingly, from Section 71, the National Scheme of Assistance for Prevention of Alcoholism and Substance Abuse emerged which catered to provide financial assistance for NGOs to provide preventive, treatment and rehabilitation services to the drug using population. The Ministry of Social Justice and Empowerment was the nodal agency for demand reduction in the country.

KEY FINDINGS ON TREATMENT AND REHABILITATION

Availability of services	Unavailability of services
Detoxification services	Admission for children and women drug dependents
Allopathic treatment	Siddha, Ayurvedha and other indigenous treatments
Voluntary admission and involuntary admission in some centres	Treatment for related psychiatric disorders
Individual counseling	Basic sanitation facilities
Group therapy	Nutritional food
Lecture sessions	Harm reduction measures/ substitute therapy
Family therapy	Yoga therapy classes
Basic follow-up services	Legal assistance for patients
Abstinence based model of treatment	Awareness cum de-addiction camps in communities (norm of scheme)
	Workplace prevention programmes

Gaps in Accessibility

- Integrated Rehabilitation Centre for Addicts registered with the Ministry are non-existent in reality within interior districts of a state
- Transport constraints faced by family members to travel to the centre
- Restricted admission for severely dependent patients on hard drugs like heroin, cocaine and synthetic drugs
- Restricted admission for HIV positive and TB patients
- Cost of food was high although treatment is free
- Stigmatization of use – Hesitance of family members to visit a de-addiction centre
- In-treatment duration is minimum one month which results in economical burden for the family as the dependent

becomes unemployable

Gaps in Quality of services

- The norms as specified in the Minimum standards of services were not followed in the centres properly
- Professional counselors and social workers were not appointed in the centres, which resulted in
- compromised outcome out of the counseling sessions.
- Awareness generation programmes were organized mostly for the motive of publicizing their centres. Lack of emphasis on preventive education and awareness in society.
- Space allotted for counseling, group therapy and family classes was not very spacious to accommodate all patients.
- Sixty percent of patients relapsed after undergoing treatment
- Simple replication of other centres' treatment model without any research and innovations
- Female counselors and male patients face difficulty in counseling sessions when sharing and dealing with sensitive issues during counseling sessions

Gaps in Protection of Human Rights

- Involuntary admission: Patients were forcefully admitted only with the consent of family members with rescue vans from their homes to the centres
- Certain centres jailed the patients and disallowed them to visit their family members. The staff at the centres assumed that only if they were disallowed to meet their family members, the patients will realize their presence and importance.
- The patients were forced to do all the odd chores at the centre and if they disobeyed, they were assaulted and physically abused
- Lack of space: 30 – 35 patients were lodged in the space which was fit only for 15- 20 patients.
- There were reports of escapism of patients and incidences of mysterious murder which had taken place in few centres.
- Certain centres believed in negative reinforcement as a technique for recovery of patients. They believed that through punishment and insult the patients will change for the better. Dignity of the individual was not upheld at all.
- Discrimination of HIV patients led to restricted admission and referral to other hospitals
- Certain patients underwent in-treatment for more than 2 months by paying expensive fees as the family members did not want them back home but were willing to pay. In such cases the patient without his will was jailed in the centre unwillingly.
- Misappropriate use of Anti-abuse tablets (Disulfiram) by patients after discharge resulted in emergencies and sometimes even proved fatal.
- Lack of expertise among staff resulted in restricted admission of narcotic drug dependent patients
- Lack of care & management of withdrawals resulted in chaining the patients to their beds and assaulting them if they showed aggressive withdrawal symptoms instead of proper medications and timely care
- Drug dependents who were referred through police custody faced the most violations in the centres.
- Lack of provision of legal assistance for patients who needed it.

POLICY RECOMMENDATIONS

a) Anti death penalty law

Section 31A was incorporated in 1989 after the Parliament passed the NDPS (Amendment) Bill, 1988. The issue of mandatory death penalty for drug offences is excessive, unscientific and inhumane. Poor drug users are soft targets for law enforcement and they are unable to afford legal representation and plead guilty for crimes they have not committed. This section has to be removed from the Act through an amendment and it is in the hands of the judiciaries and parliamentarians of the country to take this giant leap and stand up for the right to life for drug dependents.

b)Need for Convergence between Ministries

The role of Ministry of Health and Family Welfare in the area of drug de-addiction is demand reduction by way of providing treatment services alone. The de-addiction programmes in India developed by the two ministries, Ministry of Social Justice and Empowerment and Ministry of Health and Family Welfare appear to run in parallel lines to each other with little or no cooperation between the two agencies. While Addiction is considered as a disease, it is not seen from the purview of health department but treated as a moral issue or a correctional disorder.

Demand reduction by way of treatment alone is the concern of Ministry of Health and Family Welfare. It does not provide after care and rehabilitation services. However, the activities of boththe Govt. agencies overlap considerably in several ways. It is recommended that both the ministries' resources and expertise should be converged for the betterment of services provision to drug dependents. At the policy level amendments has to be made for coalition of ministries to work together.

d) Replacement of imprisonment with rehabilitation

The funds exhausted for maintaining the drug dependents in prisons can be utilized sensibly by the Government to set up more human resources and establish an independent commission for executing the demand reduction programme. Instead of receiving medical assistance, drug dependents are prosecuted and jailed, which worsens their condition. Those prisons are not conducive to treatment and rehabilitation, which the NDPS Act itself aims to secure. Therefore those persons who are under police custody and are proven to be drug dependents should strictly be referred to de-addiction centres and not jailed.

e) Differentiation of alcoholism and substance addiction

The Government of India conveniently included treatment for alcoholic patients along with treatment of patients dependent on hard drugs. The dynamics and needs of the drug dependents are way different from the dynamics of alcoholic dependents. The withdrawal symptom of substance dependents is very intense when compared to that of withdrawal symptoms of alcohol addiction. Treating different profiles of drug dependents in the same centre may not be advisable as low profile dependents may be exposed to different kinds of drugs from other patients. Group sessions and lectures can also not be given in a similar manner. Section 71 of the NDPS Act, states that de-addiction centres be established for voluntary treatment & rehabilitation of drug dependents. Such voluntary treatment was meant for persons who were dependents of narcotic drugs and psychotropic substances as per the NDPS Act. The main reason for the emergence of the section was to provide treatment instead of prosecution.

Thereby, the scheme of assistance for prevention of alcoholism and substance abuse emerged from the spirit of Section 71 of the NDPS Act. But inclusion of treatment for alcoholic patients in the de-addiction centres cannot be justified as alcohol was not mentioned in the list of narcotic drugs or psychotropic substances in the NDPS Act.

f) Diverse spread of voluntary organizations

The presence of Voluntary organizations is not uniform throughout the nation. Similarly, there are certain spheres of activities that attract more voluntary organizations just as their concentration in some regions. This twin situation often

results in disparate development of regions as well as of sectors. It is the intention of the Ministry to encourage the horizontal spread of development alongside sectoral growth in spheres that have received comparatively less attention or may need more attention. For example, the North eastern part of India needs more concentrated and even spread of voluntary organizations than the other regions as it has high rate of addiction.

RECOMMENDATIONS FOR SOCIAL INTEGRATION

a) At school level

There has not been any concrete effort taken by the Department of Education in inculcating modules in the curriculum for awareness on ill effects of drug use among school children. The new National Policy on Narcotic Drugs and Psychotropic substances which came about in 2012 has suggested inclusion of mandatory chapters of drug use and effects in the curriculum for Higher secondary students. Education on drug dependency should become a part of the curriculum. More focus should be given to the age group of 13 to 18 years who are more susceptible to drug abuse.

b) Medical management of addiction to hard core drugs

Drug dependents addicted to hard core drugs like heroin, cocaine and other opiates do not get admitted easily in de-addiction centres/voluntary organizations because of lack of expertise to manage the withdrawal symptoms posed by the patients. Training and capacity building of service providers is a must at the grass root level for treating and rehabilitating persons who are dependent on hard core drugs.

c) Women and children

The present demand reduction programme studied under the research project does not provide exclusive services to women or children drug dependents. The de-addiction centres are not equipped with enough resources to cater to women or child drug dependents.Therefore, the Ministry should undertake a study and look into the concentration of are women and children drug dependents region wise. For example, the population of street children who are dependent on drugs are majority in Mumbai and the ratio of women drug dependents are relatively high in the North eastern regions. Accordingly, de-addiction centres should be established through NGOs exclusively in such regions.

d) Inclusion of Harm Reduction Measures

Harm reduction model helps in reducing the harms inflicted to and by the dependents. When drug dependents associated with criminal behaviour are introduced to abstinence model of treatment, it is not very effective in the rehabilitation process. Further, injecting drug users are high risk groups for contracting HIV, AIDS. They face many other health ailments and as a result they die at a very early age. Therefore, in order to reduce the impact of addictive behaviour, harm reduction strategy acts as a very good alternative and effective process. Patients who are dependent on opiates can be given substitution therapy with buprenorphine and methadone under the demand reduction programme. Injecting users should be given needle exchange programme which will reduce the risk of contracting HIV and AIDS.

e) Indigenous models of treatment

In very few NGOs of the country, yoga techniques are profoundly inculcated in the de-addiction services. Ayurvedha, Siddha and Unani medicines are also used for de-addiction but in very few centres. The effectiveness of these services in no way can be underestimated when compared to the allopathic medicine. However Allopathic medicine is widely used for medical management of addiction across the country. The concerned ministry dealing with drug abuse in the nation should deploy more resources to research into the effect of indigenous medicines on addiction.

CONCLUSION

Drug policies around the world have proven to be largely ineffective in controlling the production of illegal narcotics. With very few exceptions, national drug laws and policies seek primarily to punish illicit drug production, possession, use and even dependence. In the worst cases, drug users are made to be scapegoats for a wide range of social problems, and sanctions are vastly disproportionate to the supposed offenses. According to the 2010 World Drug Report there is currently more opium, more coca and more cannabis on the market than ever before. Designer drugs are also on the rise, and amphetamines are being produced on an alarming scale.Not only have these policies been unsuccessful, they have had a broad range of destructive consequences for both individuals and society. Around the world, drug policy is characterized by heavy-handed and punitive law enforcement strategies absent of a public health or human rights framework. These policies have failed to reduce drug use and have exacerbated the spread of HIV and hepatitis C.
Legalization of drugs could pave a way for decrease in users involved in drug crimes as they are usually soft targets of drug mafias. The funds which Government spends for enforcement activities for dealing with drug offences will also decrease. Instead the funds can be used for treatment and rehabilitation of drug users and for preventive education and awareness for curbing initiation of new drug users. The Government of India should be able to curtail the criminalization approach towards drug users at the earliest. The Parliament is presently reviewing amendments to the NDPS Bill. Will the rhetoric of 'tough on drugs' prevail once again? Or will India be able to act as a mature and responsible society which limits the offences and spend more on rehabilitation of the drug dependents and on preventive education. It is an acid test for drug policy reformers as well as human rights advocates, both of whom would like to see India move in the latter direction.

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